CAROLINA ACCESS OVERVIEW

Goals: Improve access to primary care and provide a more cost efficient health care system for Medicaid recipients.

Approach*:* Link Medicaid recipients with a primary care provider who delivers and coordinates their health care needs.

Carolina ACCESS

Carolina ACCESS is a Primary Care Case Management (PCCM) program which began in North Carolina in 1991. PCCM means Medicaid recipients are linked with a primary care provider who acts as a gatekeeper to provide or arrange for most of the patient's health care needs. Primary care providers bill fee-for-service and are reimbursed based on the Medicaid fee schedule. As of April 2003, they also receive $1.00 per member per month for coordinating the care of recipients enrolled with their practice. Carolina ACCESS is operational in all 100 counties. It is administered through the Division of Medical Assistance. Carolina ACCESS is the foundation for ACCESS II and III.

ACCESS II and III

ACCESS II and III are enhanced primary care programs implemented in July 1998. They were designed to bring together primary care providers, hospitals, health departments, departments of social services, and other community providers to manage the health care needs of Medicaid recipients. ACCESS II includes 10 integrated networks. ACCESS III includes countywide partnerships in 3 counties. In addition to a primary care provider, ACCESS II and III enrollees have care managers who assist in developing, implementing, and evaluating enhanced managed care strategies at each site. ACCESS II and III providers receive $2.50 per member per month and the demonstration sites are paid an additional $2.50 per member per month care management fee. ACCESS II and III are administered through the Office of Rural Health in conjunction with the Division of Medical Assistance.

Recipient Enrollment and Education

Each county department of social services is responsible for enrolling recipients in Carolina ACCESS or ACCESS II/III. They also educate enrollees on how to use the plan, emphasizing the need for regular preventive health visits.

ENROLLMENT: Carolina ACCESS benefits and requirements must be explained to all mandatory and optional Medicaid applicants and recipients in all counties. The majority of children and their caretakers and blind and disabled recipients under age 65 are required to enroll in Carolina ACCESS or ACCESS II or III. Enrollment is optional for Medicaid recipients who also receive Medicare, pregnant women, and children who are in foster care or receive an adoption subsidy. Recipients who reside in a nursing facility, recipients age 65 or older who reside in an adult care home, illegal aliens, and refugees are ineligible to enroll in Carolina ACCESS.

Recipients are enrolled in **Carolina ACCESS** or **ACCESS II** or **III** at the time of initial application or re-certification for Medicaid. Each eligible recipient chooses a primary care provider from a list of participating PCPs. Each family member may have a different PCP if they so choose. For example, a mother may choose a family practitioner for herself, and a pediatrician for her children. ***The name of the primary care provider, along with the address and telephone number, will appear on each family member's individual Medicaid card the following month.*** It is important that recipients to show this card whenever they go for medical care. Recipients may change providers by contacting their department of social services.

Education: Carolina ACCESS and ACCESS II and III strive to provide preventive care and reduce inappropriate use of the emergency room for routine medical care. In doing so, it is essential that patients receive education on how to appropriately access their medical provider.

The education of recipients about the particular managed care program in which they are enrolled is critical. At enrollment, rectification, or as needed, the county income maintenance worker (IMC) stresses the following with the applicant/recipient:

- ✓ Get established with your PCP IMMEDIATELY.
- ✓ Take your **current month** Medicaid card when seeking any medical service.
- ✓ Call your PCP before going to any other doctor.
- ✓ Call your PCP before going to the Emergency Room unless it is an emergency.
- ✓ Get your PCP's approval before seeking specialty care.
- ✓ Go for regular preventive care such as Health Check, immunizations, checkups, mammography, cholesterol and diabetic screening.
- ✓ Some services do not need PCP approval such as dental or mental health services. (The patient handout includes a complete list of exempt services.)

Primary Care Providers

As a manager of health care, the PCP plays a key role in achieving the goals of managed care to improved access to care and the reduction of unnecessary costs. PCPs set their own enrollment limits, up to a maximum of 2000 patients per physician or physician extender. Public and private practices can enroll as a PCP. Examples of PCPs include general practitioners, nurse practitioners, physicians assistants, pediatricians, obstetricians, and in certain situations specialists. To participate with Carolina ACCESS or ACCESS II or III, the provider must sign a contract agreeing to:

- ✓Operate the office a minimum of 30 hours per week;
- ✓Develop patient/physician relationships;
- ✓Manage the health care needs of enrollees;
- ✓Provide essential preventive services;
- ✓Provide or arrange for access to medical care 24 hours a day, 7 days per week,
- ✓ Maintain hospital admitting privileges or have a formal arrangement for admissions;
- ✓ Authorize and arrange referrals when needed; and
- ✓ Review Enrollment, Emergency Room, Referral, and Utilization Reports.

Primary Care Providers are partners in the education process. They use Carolina ACCESS Office Guides to explain the program and are encouraged to send welcome letters to patients who are new to their practice.

Referral Process

The PCP must assure each enrollee's access to necessary health care by arranging for after hours coverage and authorizing referrals for specialty and hospital care.

Referrals and consultations are at the discretion and control of the PCP. It is the domain of the PCP to define the scope of a referral. The process of referring a patient to a specialist is simplified to facilitate access to the most appropriate and cost effective care. Referrals can be made by telephone or in writing.

- ✓ The PCP's authorization number is provided to the specialist, who then includes this number in block 19 of the HCFA 1500 claim form.
- ✓ The scope of a referral includes the number of visits being authorized and the extent of the diagnostic evaluation.
- ✓ If the specialist needs to refer the patient to a second provider for the same diagnosis, he should inform the PCP and then provide the authorization number to that provider.
- ✓ In order to facilitate quality of care, any further diagnosis, evaluation or treatment not identified in the original referral is the responsibility of the PCP to provide or arrange.
- ✓ The PCP may authorize care retroactively; however, it is at the discretion of the PCP to do so.
- ✓ Inpatient and outpatient Hospital care - excluding emergency room and urgent care centers billing with a hospital provider number - require authorization from the PCP. The PCP's authorization number is provided to the hospital, which then includes this number in block 11 of the UB-92

Emergency Services

Treatment in an Emergency Room and Urgent Care Centers **do not require PCP authorization.** However, specialist referrals given for follow-up care after discharge from the Emergency Room/Urgent Care Center **do require PCP authorization**. The PCP authorization number is entered in block 19 on the HCFA 1500.

Exempt Services

Enrollees can receive the following services from any qualified provider who accepts Medicaid (subject to Medicaid coverage policies and limitations) without first obtaining authorization from their primary care physician:

- Ambulance
- Anesthesiology
- At Risk Case Management
- CAP Services
- Certified Nurse Anesthetist
- Child Care Coordination
- Dental
- Developmental Evaluation Centers
- Eye Care Services (limited to CPT codes: 92002, 92004, 92012, 92014, and Diagnosis codes related to conjunctivitis: 370.3; 370.4;372.0; 372.1; 372.2; 372.3)
- Family Planning (Including Norplant)
- Health Department Services
- Hearing Aids (Under age 21)
- Hospice
- Independent & Hospital Lab Services
- Maternity Care Coordination
- Optical Supplies/Visual Aids
- Pathology Services
- Pharmacy
- Psychiatric/Mental Health (Psychiatrists, Psychiatric Hospitals, Area Mental Health Programs, Psychiatric Facilities, and Inpatient & Outpatient services billed with a hospital provider number with a primary or secondary diagnosis of 290-319.)
- Radiology (only includes services billed under a radiologist provider number)
- Services Provided by Schools and Head Start Programs

Key Program Resources:

1. N.C. Division of Medical Assistance, Managed Care Section (919-857-4022)
2. Regional Managed Care Consultants
3. DMA Webpage (http://www.dhhs.state.nc.us/dma/home.htm)
4. General Medicaid Billing/Carolina ACCESS Policy and Procedure Guide
5. Enrollment, Emergency Department, and Referral & Utilization Reports
6. Automated Voice Response (AVR) system (1-800-723-4337)
7. Recipient Handbooks
8. Bilingual brochures and posters (recipient and provider)

Questions regarding Medicaid Managed Care Programs should be directed to the Managed Care Section at DMA at 919/857-4022.